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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Genesee
Township Butler
or
Village Hayward
or
City _____

Registration District No. 114 File No. ✓
Primary Registration District No. 5867 Registered No. 3

FULL NAME Mar Hattie Brown (NO. _____ St. _____ Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH July 3, 1852
(Month) (Day) (Year)

AGE 67
yrs. mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION House wife
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE Iowa
(City or town, State or foreign country)

NAME OF FATHER Mieer

BIRTHPLACE OF FATHER Iowa
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER Esther Knorr

BIRTHPLACE OF MOTHER Iowa
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant) ✓

(ADDRESS) _____

led 6-6 1921 Joel Acton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 12, 1921
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 2-12, 1921, to 7-12-12, 1921, that I last saw him alive on 2-12, 1921 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH was as follows:
110 Congestion of Stomach

Contributory 112 (Duration) yrs. mos. ds. Just Knorr
(SECONDARY)

(Signed) H. U. Higgins M. D.
2-13 1921 (Address) Portagville

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 25 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? Hayward

Former or usual residence Ky

PLACE OF BURIAL OR REMOVAL My Response DATE OF BURIAL July 12, 1921

UNDERTAKER R. D. Young ADDRESS Portagville, Mo

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____

Registration District No. _____

Primary Registration District No. _____

File No. _____ Registered No. _____

St. _____ Ward _____

(If death occurred in hospital or institution give its NAME instead of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds.	IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) _____

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____, (Month) _____, (Day) _____, (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____

Contributory
(SECONDARY)

(Duration) _____ yrs. _____ mos. _____

(Signed) _____, 191____, (Address) _____ M. _____

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 191____

UNDERTAKER _____

ADDRESS _____

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County Fernando Registration District No. 114 File No. _____
 Township Butler Primary Registration District No. 3867 Registered No. 3
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Hattie Brown

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE 67 YEARS MONTHS 1 DAYS 3 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Fernando

(STATE OR COUNTRY)

10. NAME OF FATHER don't no

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Fernando

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER don't no

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) don't no

(STATE OR COUNTRY)

PARENTS

14. INFORMANT H. A. Killian
 (Address) Portageville Mo

15. FILED 6-5-19 L. J. Goad REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-12-1921

17. I HEREBY CERTIFY, That I attended deceased from 2-10-1921, 1921, to 2-12-1921, 1921, that I last saw deceased alive on 2-12-1921, 1921, and that death occurred on the date stated above, at 12 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

congestion of Stomach

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) H. A. Killian, M. D.
 , 19 (Address) Portageville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Hayward Mo 19

20. UNDERTAKER ADDRESS

R. H. Young Portageville

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman* (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus. *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report more symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undecipherable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which gives any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.